Refer to: Pepitone-Rockwell F, Baker S, Moore DM, et al: Notes on health issues for women (Information). West J Med 134:556-561, Jun 1981

Notes on Health Issues for Women

Understanding the Medical and Psychological Aspects of Rape

RAPE HAS BEEN CALLED "the ultimate violation of self" and "is best understood in the context of a crime against the person and not against the hymen." In incidence, rape is the fastest rising violent crime in the United States, and physicians will be increasingly called upon to treat the victims.

As an act of violence, rape instills in its victims a perceived brush with death; concomitantly, the victims' responses are equally dire. This cluster of physical, emotional and behavorial responses has been identified as the rape trauma syndrome. This syndrome includes such major phobic reactions as fear of being indoors, fear of being outdoors, fear of being alone, fear of crowds, fear of people behind one and sexual fears. Other responses include self-blame, suicidal ideation, a sense of feeling out of control and shock. All of these responses are adaptive and are normal coping strategies.

Keeping in mind that victims tend to be either expressive or controlled in their responses to the trauma of rape, some hints for psychological support include the following.

- Encourage the victim to talk about her feelings, but only if she wants to.
- Try not to determine the validity of the rape; such a determination is made in the courtroom, not by physicians.
- Inform the victim of resources available to her such as police and legal procedures, information for victims of violent crimes, supportive community groups and medical facilities.
- Assume that because rape is a traumatic event, victims may show a wide range of emotional and behavorial responses.
- Try, with the victim's consent, to involve her family and friends in providing emotional support.

Medical intervention on the part of a physician may include assessment and treatment of physical injuries as well as completing the evidentiary examination. The victim needs to sign consent forms for both of these procedures *before* they are initiated. She has the right to request medical treatment only and to refuse the evidentiary examination. In any event, no information may be released unless the patient, parent or guardian gives authorization.

The physician is responsible for overseeing the following medical aspects of the effects of rape. (1) A brief history and interview should be obtained to ascertain the nature of the injuries. The victim should be asked if she has douched, bathed or changed clothes since the assault. (2) The clothing should be noted, described, reported and retained. (3) Trauma must be diagnosed and a gynecological examination made. The vagina and cervix should be examined and swabs obtained for a wet mount, acid phosphatase, dry and fixed smears. Oral and rectal swabs and smears may also be collected. (4) The possibility of pregnancy should be raised and treated with administration of 0.25 mg of diethylstilbestrol (DES) twice a day for five days if the victim was not already pregnant before the rape. Menstrual extraction two or six weeks following the rape should be discussed as well as the possibility of a suction abortion at the six-week checkup should pregnancy occur. (5) Baseline information for the presence of gonorrhea, syphilis and the less common venereal diseases should be obtained. Intramuscular procaine

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penicillin may be given prophylactically. Follow-up appointments at two or six weeks in the gynecology clinic should be given to assess gonoccocal cultures and the VDRL. The VDRL should be repeated six weeks after the assault.

Responses to rape have been compared with those experienced after trauma by victims of war. Thus, physicians must recognize the complexity of the medical and psychological problems of victims of rape.

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Battered Wives

SINCE THE PUBLICATION of Del Martin's *Battered Wives* in 1976, wife beating has become an issue of national concern, with groups as wide-ranging as women's grassroots organizations, professional practitioners, researchers and legislators becoming involved. Unlike rape and most other forms of violence against women, wife beating occurs within the confines of a relationship which, presumably, has been built on a foundation of love and trust and which has been socially approved and legally protected. The nature of the marital relationship creates a complex set of social and psychological factors with which battered wives and their helpers must cope. Like other victims of violence, a battered wife finds herself victimized twice: first by the perpetrator and second by society through its assumptions about her and how it treats her.

The danger of dealing with battered women and those who have beaten them is that of viewing them as different from other men and women. Researchers predict that up to 50 percent of American families will experience one or more episodes of violence. It is necessary, therefore, to view this issue not merely as one related to individual persons but as one having its roots in (1) historical attitudes toward women, (2) rigid sex role socialization, (3) power relationships between men and women and (4) traditional views of the nature of marriage. Data indicate that battering occurs at virtually all levels of American society regardless of socioeconomic class, ethnicity, education, employment, geographic location or other demographic factors.

The Battering Cycle and Its Consequences

Lenore Walker has identified a three-phase cycle which helps to explain the act of battering and to build a framework within which solutions can be determined. Phase I is the tension-building stage during which the man's tension and frustration grow. Phase II involves the acute battering incident during which the beating occurs. Phase III is the loving respite stage during which the man showers the woman with apologies, love, affection and gifts and promises that the abuse will not happen again. Phase III, of course, is the one which hooks the woman into staying. While his promises are easy to believe after the initial beating, as abusive incidents continue, it becomes obvious to the woman that they will not stop. By this time, however, a phenomenon called learned helplessness frequently develops, which destroys the woman's ability to leave or seek outside help.

The construct of learned helplessness describes a process wherein uncontrollable, random, noxious experiences occur and thereby limit later problem-solving and cognitive ability, cause motivational and affective disorders and decrease the behavioral response repertoire. In the case of a battered wife, the woman has "learned" that she has no control over her environment and therefore stops making any attempts to change her circumstances. Attribution theory examines the effects of a woman's perceptions of her own responsibility for the battering as well as the relationship of those perceptions to the development of learned helplessness. Learned helplessness is the consequence of a battering relationship for the woman—without intervention it will get worse; however, with help it can be reversed as the woman begins to regain control in her life.

The Woman

Walker points out that a woman remains in the battering relationship for a variety of complex